EDITORIALS

In the Name of Public Health

History, despite its wrenching pain,
Cannot be unlived, but if faced
With courage, need not be lived again.

Maya Angelou
"On the Pulse of Morning"

In the late 19th century, eugenics—a set of ideas about the biological betterment of human stock—emerged in Britain and was soon incorporated into social and public health policy in numerous settings. By the 1910s, advocates of positive eugenics in Catholic Europe and Latin America combined with pediatric and other health reformers to back family wages, universal preschools, foster care, housing codes, and school health exams, all with the goal of improving the conditions of childhood and of the human stock more generally.[1,2] During the 1920s in the Soviet Union, eugenics was construed as a form of social medicine and supported by the official public health agency. Scientists appealed to eugenics as a demonstration of the utility of genetics to public health, while the policy implications of a Bolshevik-style positive eugenics for a time coexisted with "environmentalist" social hygiene approaches.[3]

In the better-known applications of negative eugenic thinking in Protestant settings—in Scandinavia,[4,5] Great Britain,[6–8] the United States,[6,9] and, most infamously, Nazi Germany[10,11]—various interventions including sterilization were employed to "breed out" certain "defective" human characteristics, initially a variety of mental conditions and behaviors defined as criminal or immoral. Although by 1920 the Hardy–Weinberg principle[12] had shown the futility of such attempts to alter the gene pool, eugenics continued to be invoked to justify the use of sterilization practices on a widening pool of so-called undesirables, increasingly defined as immigrants, the poor, and racial/ethnic minorities.

EUGENICS, CALIFORNIA STYLE

As Stern shows in this issue,[13] perhaps nowhere were these ideas and practices as thoroughly embraced and institutionalized as in California, where a sterilization law was in effect from 1909 to 1979. In Stern's analysis, 2 key points stand out that are equally unsettling. First, Stern shows the continuities between the tens of thousands of forced sterilizations that took place in mental institutions in the early 20th century and the coercive sterilization (typically in the name of family planning) of Mexican American and other immigrant, minority, and working-class women in more recent decades. Second, she demonstrates that eugenic sterilization was not promoted and practiced by a handful of prejudiced public health officials and doctors whose activities were left unchecked, but rather was fully backed by numerous state and federal agencies and social, political, and academic luminaries. Indeed, public health and eugenics programs shared the same general goal: to improve the well-being of society, whether by altering the environment or by manipulating the gene pool.[14,15]

In correcting the perception that American eugenic sterilization was advanced by a narrow set of actors in an era long gone, Stern raises a set of disconcerting issues for public health practitioners and advocates today. The most obvious of these, and the most troubling for its contemporary resonance, is the social prejudice that marked activities pursued in the name of public health. The extent to which health and medical policies absorb and reflect the dominant class and racial logic of the time has been well documented.

As Vanessa Gamble has argued, the US Public Health Service's 40-year study of untreated syphilis in 400 Black men in Tuskegee, Alabama, represents only 1 episode in a sea of institutionalized practices and daily interactions that has produced a legacy of overtreatment, undertreatment, and mistreatment of African Americans.[16] Nayan Shah has likewise documented the portability of the health department's and the public's scapegoating of the Chinese community in San Francisco, California, from epidemic to epidemic across 2 centuries[17] (3 if we include the severe acute respiratory syndrome [SARS] epidemic of 2003). The classism of health and medical institutions—in the US context, often intertwined with racial and ethnic discrimination—reveals similarly pernicious patterns of prejudice.[18–21]

Stern investigates how public health institutions evolved into a key site of racialization from the late 19th into the 20th century.[13] Public health not only reproduced larger societal tenets but also exerted influence well beyond the profession and practice of public health. While sterilization laws may not have mentioned race and class explicitly, they were racialized and class-oriented in enforcement. Immigrants, particularly those of color, were not only sterilized in disproportionate numbers but also were marked as inferior by the practice.

California's sterilization law was justified as a preventive measure that was at the same time cost saving, desirable for the patient and her family, and good for the public. Yet, remarkably, California state legislators acknowledged that implementation of the law might result in legitimate legal claims, and in 1917 they modified the law to protect doctors who carried out state-sanctioned sterilizations from legal retaliation.[13]

This explicit recognition of the potential for violation of patients' rights was perversely echoed in the ruling in *Madrigal v Quilligan* (No. 75 Civ 2057 [CD Cal June 30, 1978], *aff'd,* 639 F2d 789 ([9th Cir 1981]) some 60 years later. Despite the existence of informed consent practices by the early 1970s—developed in part because of the involuntary sterilizations of the previous half century—the judge in this case interpreted the sterilization of the Mexican American plaintiffs to be the result of cultural misunderstanding rather than the product of powerful incentive systems for doctors to perform these procedures or of provider manipulation or of willful ignorance of patient preferences. In an inversion of their intended use, informed consent policies protected not patients but doctors, who were believed to be obtaining patients' consent properly whether or not this was actually the case.

Moreover, the racial logic that girded the sterilization projects of the 1920s was transformed and presented as a defense strategy in *Madrigal v Quilligan.* The judge did not rule against the defendants on the basis of half century–old racial logic, but he summoned a "clash of cultures" argument that nonetheless rested on a belief in racial hierarchy.

THE PAST AND THE PRESENT

On one level, *Madrigal* and other similarly reasoned decisions alert us to the need for frequent reevaluation of the measures intended to protect the public—particularly its most marginalized members—from prejudicial treatment by health institutions. In recent decades "cultural competence" has emerged as a standard of practice that puts the onus on health care institutions to take into account differential linguistic abilities and distinct cultural understandings of family, community, and medical authority and decisionmaking.[22,23] Although it is potentially useful in preventing the tragedies of medical miscommunication,[24] cultural competence already runs the risk of becoming just another item in a checklist of requirements to allay liability concerns—an item that nonetheless leaves many elements of the power imbalance between patient and institution unaddressed.

At another level, this process of reevaluation and refinement of policies may lead to frustration; if institutionally based ethical measures are not linked to larger movements for social rights, we may find ourselves developing ever more detailed ethical codes while endlessly battling class and racial prejudice.

A further jarring issue highlighted by Stern has to do with how seemingly well-understood public health activities are reshaped in various political contexts. Although many accounts portray eugenics as a unitary movement informed by conservative ideas and supported by political counterparts, it was above all a technocratic development that could be and was appropriated and refashioned by utopians, social progressives, nativists, and Nazis. The evolution of eugenic policies in Protestant countries—where sterilization was almost universally adopted as the preferred means of achieving eugenic goals—is in distinct contrast to the situation in many Catholic settings, where a positive eugenics of enhancing prenatal and childraising circumstances substituted for sterilization.

In linking eugenics to right-wing political agendas, some scholars have inaccurately pointed to the end of World War II and the discrediting of "Nazi science" at the Nuremberg trials as the demise of eugenics.[25] Yet, as Stern shows for California, eugenics did not disappear then; support for eugenic sterilization merged with growing concerns about overpopulation and family planning. Birth control, at bottom a technocratic measure, was also appropriated differentially by various actors. Seized upon as a means of freedom for elite and middle-class women, birth control has had more conflicted meanings and consequences for poor and working-class women around the world.[26–28]

In the end, we must examine the ideological footprint left by proponents of eugenics through their writings, the policies they developed, and the professionals they trained. Early eugenicists generated influential policies that helped embed racial and classist reasoning into public institutions. Stern[13] lays the theoretical groundwork for us to see how a belief in a racial and social hierarchy was at the core of sterilization projects in the 1920s and the 1970s *and* the passage of Proposition 187 in the 1990s. (Proposition 187 was approved via referendum by California voters in 1994 to prevent undocumented immigrants from receiving public benefits or services, including health care and education; it was never implemented because of legal challenges.) If we see these projects as historically linked, we cannot relegate such dangerous approaches to an unprogressive past.

The past is infinitely complex, but surely not impenetrable. Public health history teaches us that scientific and technical developments interact continuously with the political and social context and that health policies and their implementation both reflect and shape the political context and social hierarchy within particular societies. Facing history with courage compels us to raise questions of the past based on the pain of the present and to raise questions of the present based on the pain of the past. ■

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